No permit

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 20 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

10077

State File No.

Registration District No. 31 Primary Registration District No. 5040 Registrar's No. 4

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County: Barry

(b) City or town: Rural Mc Donald
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ——— (Specify whether years, months or days) In this community 3 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Barry

(c) City or town: Rural
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ——— years.

3. (a) PRINT FULL NAME: Maggie Jane Carney

3. (b) If veteran, name war: None

3. (c) Social Security No.: none

4. Sex: Female

5. Color or race: W

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Tom Carney

6. (c) Age of husband or wife if alive: 78 years

7. Birth date of deceased: Dec. (Month) 15 (Day) 1874 (Year)

8. AGE: Years 67 Months 4 Days 19 If less than one day ___ hr. ___ min.

9. Birthplace: Ill. (City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Joseph Carter
13. Birthplace: Not Known (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Not Known
15. Birthplace: Not Known (City, town, or county) (State or foreign country)

16. (a) Informant: Tom Carney
(b) Address: Purdy, Mo. R#1

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/42 (Month) (Day) (Year)
(c) Place: burial or cremation: Marrs Hill Cem.

18. (a) Signature of funeral director: Wm Marrs Bryce
(b) Address: Wheaton, Mo.

19. (a) 4/7/42 (Date received by local registrar) (b) Del Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5 year 1942 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from 3-13-42, 19__, to 4-1-42, 19__; that I last saw her alive on April 1, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death: Acute myocarditis

Due to: Hypertension Hypostatic Pneumonia

Due to:

Other conditions (Include pregnancy within 3 months of death):

Major findings:
Of operations:

Of autopsy:

Duration

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify):
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury:

23. Signature: W R McClure (M. D. or other) D O
Address: Cassville Date signed 4/6/42

(Licensed Embalmer's Statement on Reverse Side)

[illegible]

District Health Officer No. 6,

District File Number 442-513

Date Filed APR 14 1942

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~or by~~ ....., Registered Apprentice No. ....., working under my personal supervision.

Signed Wm Morris Pogue

Licensed Embalmer No. 3442

P. O. Address Wheaton, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

. S. No. 2B
DM—8-21-41
I X29288

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10077

Registration District No. 31 Primary Registration District No. 5045 Registrar's No.

1. PLACE OF DEATH:

(a) County Barry

(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Maggie J. Carney

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Dec (Month) 15 (Day) 1874 (Year)

8. AGE: Years 67 Months 4 Days 19 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day
year 1942 hour minute M.

21. I hereby certify that I attended the deceased from
19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia

Due to Chronic congestion of the lungs

Due to Chronic myocarditis and myocardial degeneration

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

109.1

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature W R M McClure (M. D. or other)
Address Cassville Date signed 5/1/42

SUPPLEMENTARY